Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SW FREEWAY SUITE 2200
HOUSTON TX 77027

Respondent Name
GREAT NORTHERN INSURANCE CO

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-08-1004-01

MFDR Date Received
OCTOBER 11, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated October 10, 2007: "It is the hospital's position that the hospitalization was an emergency as defined pursuant to the Acute Care Hospital Fee guideline. Chubb Insurance issued an underpayment of $17,793.45 as a fair and reasonable reimbursement for trauma admits. In addition, the hospital's UB92 is coded ICD 958.92 as a trauma admit."

Requestor's Supplemental Position Summary Dated December 2, 2011: "The Court further determined that to apply the Stop-Loss Exception, a hospital is required to demonstrate that its total audited charges exceed $40,000, and the admission involved unusually costly and unusually extensive services to receive reimbursement under the Stop-Loss method". "Based upon this information, Memorial Hermann has met its burden under the Stop-Loss exception and is entitled to the additional reimbursement of $33,754.99."

Affidavit of Michael C. Bennett dated November 1, 2011: "I am the System Executive of Patient Business Services for Memorial Hermann Healthcare System (the 'Hospital')." "The charges reflected on the attached Exhibit A are the usual and customary fees charged for like or similar services and do not exceed the fees charged for similar treatment of an individual of an equivalent standard of living and paid by someone acting on that individual's behalf." "On the dates stated in the attached records, the Hospital provided medical care and services to this patient who incurred the usual and customary charges in the amount of $68,731.25 which is a fair and reasonable rate for the services and supplies provided during this patient's hospitalization. Due to the nature of the patient's injuries and need for surgical intervention, the admission required unusually costly services."

Affidavit of Patricia L. Metzger dated November 21, 2011: "I am the Chief of Care Management for Memorial Hermann Healthcare System (the 'Hospital')." "Based upon my review of the records, my education, training, and experience in patient care management, I can state that based upon the patient's diagnosis and extent of injury, the services and surgical procedures performed on this patient were complicated and unusually extensive."

Amount in Dispute: $46,075.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated October 23, 2007: "The above admission is subject to reimbursement pursuant to Rule 134.401(c)(5). Reimbursement for the entire admission was based on a fair, reasonable and

consistent methodology neither the per diem method nor the stop loss method applies to this admission." "It is the carrier's position that no additional reimbursement is due to the requester for this inpatient surgery. The requester has been reimbursed a fair and reasonable reimbursement, $17,793.45 for the services rendered on 10/19/2006."

Response Submitted by: UniMed Direct, 5068 W. Plano Pkwy., Suite 122, Plano, TX 75093

Respondent's Position Summary dated October 24, 2007: "…the Requestor has been paid for the services provided to the Claimant pursuant to a rate that is fair and reasonable. It is unreasonable for the Respondent to seek 100% of billed charges."

Response Submitted by: Downs Stanford, P.C., 2001 Bryan Street, Suite 4000, Dallas, TX 75201

Respondent's Position Summary dated September 8, 2011: "…this is not a top-loss case. This admission has been paid at a fair and reasonable rate. The stop-loss exception does not apply."

Response Submitted by: Downs Stanford, P.C., 115 Wild Basin Road, Suite 207, Austin, TX 78746

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 19, 2006 through October 31, 2006	Inpatient Services	$46,075.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers compensation state fee schedule adjustment.
   - 28-The reduction was made for reasons indicated in the note below or on the attached note or letter.
   - Reimbursement is made on the revenue codes with the payment indicated. The stay is reimbursed in accordance with generally accepted amounts for same and similar services under other payors including Medicare and private carriers. The reimbursement for revenue codes showing reduced or no payment is included in the revenue codes with an indicated payment.
   - Payment determined, payment based on fair & reasonable.
   - 510-Payment determined.
   - W10-Payment based on fair & reasonable methodology.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 958.92. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers'

compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor seeks full reimbursement of billed charges based upon "It is the hospital's position that the hospitalization was an emergency as defined pursuant to the Acute Care Hospital Fee guideline."
   - The requestor did not provide documentation to demonstrate how it determined that full reimbursement of billed charges was fair and reasonable.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/30/2012 Date
Signature	Medical Fee Dispute Resolution Manager	11/30/2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.